PETITION FOR PAYMENT OF MEDICAL AND RELATED SERVICES

STATE OF MAINE
WORKERS' COMPENSATION BOARD
27 STATE HOUSE STATION
AUGUSTA, MAINE 04333-0027

EMPLOYEE	EMPLOYER
NAME: _____	NAME: _____
STREET/P.O. BOX: _____	STREET/P.O. BOX: _____
CITY, STATE, ZIP: _____	CITY, STATE, ZIP: _____
TELEPHONE NUMBER: _____	INSURANCE COMPANY
EMPLOYEE SOCIAL SECURITY NUMBER: XXX-XX-_____	NAME: _____
BOARD FILE NUMBER: _____ (IF KNOWN)	STREET/P.O. BOX: _____
	CITY, STATE, ZIP: _____

1. On _____ (MONTH DAY YEAR), _____ (EMPLOYEE NAME)
   experienced a work-related injury while working for _____ (EMPLOYER NAME).
2. Describe how the injury occurred:

   _____

   _____
3. List body part(s) injured:

   _____
4. The charges for medical and related services such as prescriptions and mileage in connection with this injury amount to: $_____ (ATTACH COPIES OF ALL BILLS).

WHEREFORE, the employee asks the Board to order payment of the attached work-related medical bills and services pursuant to 39-A M.R.S.A.

_____
SIGNATURE OF EMPLOYEE

DATED: _____
MONTH DAY YEAR

_____
NAME OF EMPLOYEE'S ATTORNEY OR ADVOCATE (IF ANY)

_____
STREET/P.O. BOX

_____
CITY, STATE, ZIP

FILING INSTRUCTIONS

1. Mail original petition to the Workers= Compensation Board at the above address by regular mail.
2. Mail one (1) copy **by certified mail, return receipt requested** to the insurance company.
3. Mail one (1) copy **by certified mail, return receipt requested** to the employer.
4. Keep one (1) copy for yourself and keep the green certified mail cards when returned to you by the U.S. Post Office.